

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 22 1957

STATE FILE NUMBER 12352  
REGISTRAR'S NO. 95

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 95

Health, S. & Welfare S. Public Health Service

S. 300 1-57 2

securing the medical certification in the specific manner required by 172.010-172.015 R.S.M.S. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Montgomery</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Americus</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #1</b>		Length of stay in 1b <b>1 yr. 6 mo.</b>	d. STREET ADDRESS (If outside, give location) <b>-----</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Wm</b> Middle <b>Stockhorst</b> Last <b>Stockhorst</b>			4. DATE OF DEATH Month <b>4</b> Day <b>15</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1880</b>	9. AGE (In years or birthday) <b>76</b>	10. FUNDERS YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (City and state or country) <b>Montgomery County, Mo.</b>	
13a. FATHER'S NAME <b>William Stockhorst</b>		13b. MOTHER'S MAIDEN NAME <b>D.K.</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Lizzie Stockhorst</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT Address <b>State Hospital #1; Fulton, Missouri</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Sen. arteriosclerosis</b> DUE TO (c) <b>Dronation</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 2 2 1</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year o.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. Attended the deceased from <b>Oct. 15 - 57</b> to <b>April 15 - 57</b> and last saw her alive on <b>4/14/57</b> Death occurred at <b>6:20 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Wm. J. Adams M.D.</b>			22b. ADDRESS <b>State Hosp - Fulton</b>		22c. DATE SIGNED <b>4/15/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-17-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Martins</b>		23d. LOCATION (City, town, or county) (State) <b>Starkenburg Mo.</b>
24. FUNERAL DIRECTOR <b>H. B. Baker</b>		ADDRESS <b>Americus Mo</b>		25. DATE RECD. BY LOCAL REG. <b>April 15 - 1957</b>	26. REGISTRAR'S SIGNATURE <b>Margaret Lawrence</b>

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *D B Baker* .....

Licensed Embalmer No. 3375 .....

P. O. Address *Americus, MO* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.